NEVADA RYAN WHITE UNIVERSAL ELIGIBLITY MANUAL

Instructions for Completing Common Guidance Documents 18-04, 18-05, 18-06

Common Guidance Document – 18-04
Universal Eligibility Application – Brand New Client

Application Date: _____

For Administrative Use Only:
New Ryan White Eligibility: Start Date: _____ End Date: _____
Case Manager/ Eligibility Specialist Name: _____

Application Date:

- Date the **complete** application was received by the processing agency.

Start/End Dates

The Eligibility Start and End dates are determined by the actual birth month of the client

New Ryan White Eligibility - Start Date:

The Eligibility Start Date will always be the date the client has completed the eligibility packet.

New Ryan White Eligibility – End Date:

The Eligibility End Date day will always be the last day of the month.

Notes:

The Case Manager will identify the client's birth date and follow the chart below.

Eligibility Start Date	Eligibility End Date
January 1st – 31st	July 31st
February 1st – 28th	August 31st
March 1st – 31st	September 30th
April 1st – 30th	October 31st
May 1st – 31st	November 30th
June 1st – 30th	December 31st
July 1st – 31st	January 31st
August 1st – 31st	February 28th
September 1st – 30th	March 31st
October 1st – 31st	April 30th
November 1st – 30th	May 31st
December 1st – 31st	June 30th

Gap Certification/Alignment

In order to align a client to birthday/Half-birthday eligibility dates Eligibility Specialist must:

1. Identify the birth month of the client.

2. Identify how many months until the client's birthday. This will be the initial period of eligibility. The table below provides a timeline for enrolling clients. If the client birthday Is less than one month away, they would receive eligibility for just under 7 months (or 6.9999 months of eligibility), if the client's birthday is 2 months away then they would receive only 2 months of eligibility and so on as indicated in the table below:

How many months until the client's birthday?	How long are the initial eligibility period and the gap certification (in months)?
<1	Up to 6.9999
2	2 (gap certification)
3	3 (gap certification)
4	4 (gap certification)
5	5 (gap certification)

3. Count forward how many months are left until the client's birthday from the day you are completing eligibility until their birthday. This is their gap certification.

Example: *Clients completes his/her packet on 9/28/18. A Client has a birthday in October. Since that is less than one month away, the client would receive eligibility from 9/28/2018 to 04/30/2018*

Case Manager/Eligibility Specialist Name:

- Input the name of the Case Manager/Eligibility Specialist processing the application.

COMMENTS:_____

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CONTACT INFORMATION

CONTACT INFORMATION

Legal Last Name:		**Legal First Name:**		**Middle Name:**	
Birth Date:		**Preferred Name or AKA:**			
Language Preference: ☐ English ☐ Spanish ☐ Other: _____		**SSN or TIN*:**			
Home Address:		**City:**	**State:**	**Zip:**	
Mail Address *(if different than home):*		**City:**	**State:**	**Zip:**	
1. Phone – include area code:	**Type:**	**May we contact you by mail?**	☐ Yes	☐ No	
2. Phone – include area code:	**Type:**	**Should mail be confidential?**	☐ Yes	☐ No	
		May we contact you by phone?	☐ Yes	☐ No	
E-mail Address:	**Okay to E-Mail?** ☐ Yes ☐ No	**May we leave a message?**	☐ Yes	☐ No	

**SSN information is not used for eligibility. It is used to verify Medicaid or Health Insurance information.*

Process

1. Legal Last Name: Fill in with the clients actual LAST name, as provided.
2. Legal First Name: Fill in with the clients actual FIRST name, as provided.
3. Middle Name: Fill in with the Clients actual MIDDLE name, as provided.
4. Birth Date: Use the Drop-Down menu to determine the month, date and year client was born.
5. Preferred Name or AKA: (Optional) Fill in with any known alias, or preferred name, as given.
6. Language Preference: Check if language of choice is English, Spanish or Other. If other fill in the language identified.
7. SSN or TIN: Fill in with clients Social Security Number or other identifier, please read disclaimer that this information is used only to verify Medicaid or Health insurance information. If client does not or unable to provide you with a SSN or TIN put N/A. (optional)
8. Home Address: Home address where client resides. (if client has no address, ensure that client completes the attestation of homelessness).
9. City: Current city that client is living in. (If this is not a Nevada city, client does not qualify)
10. State: Put in Nevada. (Client must be a resident of Nevada to qualify)
11. Zip: Use current (Nevada) Zip Code.
12. Mail Address: Only if different from Home address.
13. City: Only if different than (home) Home Address.
14. State: Only if different than (home) State but must still be Nevada.
15. Zip: Only if different than (home) Zip but must still be a Nevada State Zip Code.
16. Phone: Fill in with current primary phone number where client can be reached.
17. Type: Fill in what type of phone it is (cellular, land line etc.)
18. Phone: Fill in with current Secondary phone where they can be reached (Optional)
19. Type: Fill in what type of phone it is (cellular, land line etc.)

20. E-Mail Address: Fill in with a client's email (if available).
21. Ok to Email: Acknowledgment that the case manager can communicate with the client via email.
22. May We Contact You By Mail: Does the client give his consent to receive email from the provider.
23. Should mail be confidential: Does the client prefer to have mail from the agency marked as private or confidential?
24. May we contact you by phone: Acknowledgment that the case manager can communicate with the client via telephone.
25. May we leave a message: When a client is not readily available, can the Case worker leave a message for the client at the contact number.

Notes:

For Emergency Shelters (Trafficking Victims)

- Use client's P.O. Box for mailing address
- Write "confidential address" on the physical address section and also in CAREWare Demographics tab
- Choose Verification of Residence Form or Letter from Landlord in the residency documents section and attach the letter from the landlord/agency representative

EMERGENCY CONTACT

An emergency contact is the first person case managers will get in touch with in a client related emergency. This information is a confidential personal record and is only provided to others on a need-to-know basis.

EMERGENCY CONTACT					
Name:		1. Phone – include area code:		Relation to the Client?	
Address:		City:		State:	Zip:
Notes:		Aware of status? ☐ Yes ☐ No			

Process

1. Name: Fill in the First and Last name of the emergency contact identified by the client.
2. Phone: Fill in the telephone number where the emergency contact may be reached.
3. Relation to the Client: What is the relation between the client and their emergency contact.
4. Address: Current address (mailing or physical) of emergency contact.
5. City: Current address of emergency contact.
6. State: Current State where the emergency contact presides.
7. Zip: Current zip code where the emergency contact presides
8. Notes: Has the client given the case manager any special information that the case manager should be made aware of when dealing with client's emergency contact.
9. Aware of status: Is the emergency contact aware of the client's HIV status.

Notes:

- An emergency contact doesn't have to be a close relative or friend. It can be literally anybody.
- If it is truly the case that a client literally doesn't identify an emergency contact it's also OK to just not have an emergency contact.
- If the emergency contact does not know the clients status, it is up to the case manager to keep said status confidential when communicating with the client's emergency contact.

COMMENTS:_____

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DEMOGRAPHICS

Demographic information allows us to better understand certain background characteristics of our clients. This information helps the Ryan White Program communicate effectively with our service community, as well as understand our client(s) varied cultures, which may affect their health.

DEMOGRAPHICS	
Current Gender Identity: ☐ Male ☐ Transgender Male-to-Female (MTF) ☐ Female ☐ Transgender Female-to-Male (FTM) ☐ Other ☐ Transgender Other	**Sex at Birth:** ☐ Male ☐ Female
Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino, (*if checked, choose an option below)* ☐ Mexican, Mexican American, Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Another Hispanic, Latino/a or Spanish origin	**Race:** ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Pacific Islander (*if checked, choose an option below)* ☐ Native Hawaiian ☐ Guamanian/Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Asian (*if checked, choose an option below)* ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian
Relationship Status: ☐ Single ☐ Married ☐ Domestic ☐ Unmarried Couple ☐ Divorced ☐ Separated ☐ Widowed	
Education Level: ☐ No High School ☐ Some High School ☐ High School Diploma/GED ☐ Trade/Technical School ☐ Some College ☐ College Degree ☐ Graduate Degree	
Are you a veteran? ☐ Yes ☐ No	

Process

1. Current Gender Identity: How does the client currently identify themselves.
2. Sex at Birth: Check the appropriate box of the client's sex at birth.
3. Ethnicity: Check the box(s) that most accurately identify the client.
4. Race: Check the race that most accurately identifies the client.
5. Relationship Status: Check the choice which the client has identified.
6. Education Level: Check the highest level of education the client has achieved.
7. Are you a veteran: Is the client a veteran of the armed forces.

COMMENTS:_____

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HIV/AIDS STATUS AND DIAGNOSIS INFORMATION

An applicant is required to have documentation of a medical diagnosis of HIV disease with a laboratory test document confirmed HIV infection for their initial determination of eligibility.

HIV/AIDS STATUS AND DIAGNOSIS INFORMATION

HIV/AIDS Status: ☐ HIV Positive (not AIDS) ☐ HIV Positive (AIDS status unknown) ☐ CDC Defined AIDS
☐ HIV Negative (Affected) ☐ HIV Indeterminate (infants <2 years old)

Date of First HIV+ Diagnosis:	☐ Estimated?	Date of First AIDS Diagnosis:	☐ Estimated?

How do you believe you contracted HIV?

☐ Male to Male sexual contact
☐ Injection Drug Use
☐ Heterosexual Contact
☐ Hemophilia/Coagulation Disorder
☐ Recipient of transfusion of blood, blood components, or tissue
☐ Perinatal Transmission
☐ Undetermined/Unknown, risk not reported or identified
☐ Other, please specify: _____

Process

1. HIV/AIDS Status: Check which choice best describes the client's current status:
   - HIV Positive (Not AIDS)
   - HIV Negative (Affected)
   - HIV Positive (AIDS status unknown)
   - HIV Indeterminate (infants <2 years old)
   - CDC Defined AIDS
2. Date of First HIV+ Diagnosis: Fill in with the date from documents, or if the client has no documentation have the client give an estimated date.
3. Estimated: Check only if the Date of First HIV Diagnosis was estimated by client.
4. Date of First AIDS Diagnosis: Fill in with the date from documents, or if the client has no documentation have the client give an estimated date.
5. Estimated: Check only if the Date of First HIV Diagnosis was estimated by client.
6. How do you believe you contracted HIV: Check which one best applies according to client's comments.

PROOF OF DIAGNOSIS

Documentation of HIV-positive status must be reviewed during onsite and/or remote visits and confirmed before initial enrollment by a case manager.

PROOF OF DIAGNOSIS

All clients must provide upon **initial enrollment only** one (1) medical/legal document from the list below indicating HIV infection.

- Please select *one* option from the list below and **attach a copy** to this application

Proof of Diagnosis Documents
☐ Western Blot
☐ Letter on physician's letterhead, with signature of doctor, indicating that the applicant is HIV positive with diagnosis date.
☐ Electronic medical record from physician's office, with electronic signature of doctor, indicating that the applicant is HIV positive.
☐ Positive HIV test (immunoassay) and detectable viral load (HIV RNA)
☐ Two positive HIV tests (immunoassays- should be different assays based on different antigens or different principles)
☐ Request for Proof of Diagnosis Form completed by applicant's physician (CGD 15-39)

Process

The Eligibility Specialist will initiate the required documentation of confirmed HIV status through one of the following:

1. Western Blot:
2. Letter on physician's Letterhead
3. Electronic medical record from physician's office
4. Positive HIV test (immunoassay)
5. Two positive HIV tests
6. Request for Proof of Diagnosis Form (CGD 15-39)

Notes:

- Any proof of diagnosis document must include the applicant's full, legal name.

- A medical provider may submit a written statement confirming HIV diagnosis, on agency, clinic or public health department letterhead, a prescription pad or medical record is acceptable. All medical providers' electronic medical record with signature is acceptable when warranted.

- A client may also provide a Request for Proof of Diagnosis Form (CGD 15-39).

COMMENTS:_____

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BASIC MEDICAL

BASIC MEDICAL	
Primary Care Physician Name:	**HIV Specialist Name:**
How do you obtain primary HIV medical care?	
☐ Publicly-funded clinic or health district	☐ Hospital Outpatient Center
☐ Private Practice	☐ No primary source of care
☐ Emergency Room	☐ Other: _____

Process

1. Primary Care Physician Name: Client should identify their primary physician
2. HIV Specialist Name: Client should identify their HIV Specialist (if different from primary physician)
3. How do you obtain primary HIV medical care: Check whichever is most appropriate to where the client receives their primary HIV medical care.

COMMENTS:_____

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RESIDENCY

RESIDENCY

What is your current housing status?

☐ I live in stable housing (includes HOPWA): ☐ Rent ☐ Own ☐ Long-Term Care Facility

☐ I live in temporary housing: ☐ Friends/Family (including couch-surfing) ☐ Hotel/Motel ☐ Transitional Housing or Treatment Center

☐ I live in unstable housing: ☐ Homeless/Emergency Shelter ☐ Jail/Prison/Detention Facility

Process

Please check which option best suits the clients described **current** living conditions.

1. Stable Housing
   - Rent: Client is not the primary mortage holder.
   - Own: Client (or family member) is the prmiary mortage holder.
   - Long Term Care Faclity: A facility that provides rehabilitative, restorative, and/or ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living.

   Temporary Housing
   - Friend/family (couch surfing):
   - Hotel/Motel
   - Transitional Housing/Treatment Facility: This would include ½ way houses
2. Unstable Housing
   - Homeless/Emergency Shelter: This would include safe shelters for abuse victims.
   - Jail/Prison/Detention Center (**see Notes below**)

Notes:

- If the client is to be incarcerated for a time period greater than 3 months they are **not Ryan White eligible**, please refer the client to the Department of Corrections for further assistance.

- If the client will be incarcerated (Jail/Prison/Detention Center) at the time and is due to be released within 3 months, refer the client to SNHD's EIS program.

COMMENTS:_____

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Residency Documents

For eligibility, residency refers to clients who make Nevada their home. A specific number of weeks or months in Nevada are not required to be considered as a resident in Nevada; however, a client's intent to remain in Nevada is of interest, particularly for medical and treatment services

All clients must provide one (1) residency document from the list above indicating Nevada residency.

Residency Documents	
☐ Current Lease/Rental Agreement	☐ Current Nevada Driver's License or State ID Card
☐ Rent/Mortgage Receipt (dated within the past 30 days)	☐ Consulate Identification Card
☐ Any Bill, Invoice, or Correspondence (dated within the past 30 days)	☐ Resident Alien Card
☐ Paycheck Stubs with Your Address	☐ Proof of Property Taxes Paid
☐ Letter from a Government Agency	☐ Voter Registration/Vehicle Registration
☐ Other Verifiable Government-Issued ID with Address	☐ Prison Release Papers
☐ Dependent Support Form (CGD 15-48) or a Letter: *See below*	☐ I am Homeless: *Complete the Attestation of Homelessness Below*
☐ Verification of Residence (CGD 15-50) or a Letter from Landlord	
If you cannot provide residency proof in your own name, please complete the Dependent Support Form (CGD 15-48) or submit a letter with your current address and a signature of person(s) providing support.	

Process

Select one (or more) documents that were provided by the client for verification from the list below and attach a copy to the client's application. If document provided is not listed ensure that residency documentation include the client's name and a listing of a residential address that corresponds with the address given in their application.

- Current State Nevada driver's license or State ID Card
- Housing, rental, or mortgage agreement in client's name
- Any bill, invoice or correspondence dated within 30 days of application.
- Paycheck Stubs
- Bank Statements
- Official correspondence from a Government Agency
- Over verifiable government-issued ID (with corresponding address)
- Consulate Identification Card
- Resident Alien Card
- Property Tax Receipt
- Current Voter Registration
- Vehicle Registration
- Prison Release Papers (if recently released)
- A statement from the shelter in which the client resides or visits (see Attestation of Homelessness)
- A statement from a Social Service agency attesting to the homeless status of the client. (See Attestation of Homelessness)

The following Nevada Common Guidance Document(s) may also be used to establish residency:

- CGD 15-48 Dependent Support Form
- GCD 15-50 Verification of Residence

Notes:

- United States citizenship is not a requirement of Ryan White eligibility
- Remind client that **IF** their address changes at any time, to contact an Eligibility Specialist or Case Manager to update their address.
- **The residency address may be a PO Box if:**
  1. The recipient has another means to verify the address (such as a utility bill)
  2. If the United States Postal Service (USPS) has not established a residential address for the location. This is often the case on Native American Tribal Reservations.

COMMENTS:_____

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Attestation of Homelessness

If client states that she/he is homeless or lying-in a shelter with no verifiable residence please have them complete the Attestation of Homelessness in the initial and/or annual recertification application.

Attestation of Homelessness
I attest that I am homeless or living in a shelter with no verifiable residence. I agree that if my residency status changes, I must immediately notify the Ryan White Part All Parts (ABCD) eligibility agency and provide documentation of residency. Client Signature: _____ Date: _____

Process:

1. Client Signature: Have the client sign here.
2. Date: Use the drop-down box to affix the month, day and year that this attestation was signed.

COMMENTS:_____

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HOUSEHOLD SIZE

A household includes the client, members of his/her family, and certain other adults who live together as a unit. The size of the household assists in determining the client's FPL.

HOUSEHOLD SIZE

List members of your household, such as a legal spouse and children who live with you, ***and*** anyone you will claim as a dependent on your taxes.
Please list yourself first.

Client or Family Member Name	Relationship to Client	Does this person have Taxable Income?	Over age 18?	Claimed on Taxes?
	Self	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Total Household Size: _____

Process

1. Client or Family Member Name: In the first line put in the client, any other family members will follow in the lines below.
2. Relationship to client: In the first line "self" refers to the client. All others must provide the relationship (wife, son, daughter, etc.) to the client.
3. Does this Person Have Taxable Income? Does the identified relative hold a job or is making any taxable income. Yes or No.
4. Over the age of 18: Is the identified relatives over the age of 18. Yes or No.
5. Claimed on taxes: Is the relative claimed on as part of the CLIENTS' taxes. Yes or no.
6. Total Household Size: Input the number of identified family member, including the client.

Notes:

A dependent is defined by the following is an individual who expects to be, or is claimed by the client on their taxes.

A tax dependent assistance unit will be the same as the individual who is claiming them as a dependent, UNLESS:

- They are or expect to be claimed by another Individual who is not a spouse or a biological, adoptive or stepparent.
- They are a child under the age of 19, living with both parents and the parents do not file a joint tax return.
- Or they are a child under age 19 and are being claimed by a non-custodial parent.

If the tax dependent meets one of the above exemptions, they are considered a Non-Filer.

Not counted in household size are:

- Roommate(s) with separate finances who share only the cost of room and board. Room and board include household expenses, such as utility, cage, phone, rent or mortgage, and meals.
- Adults, such as a parent, adult siblings, adult children, significant others, and partners who live with the client but have separate finances and/or share only household expenses.
- Live-in aids who receive payment for their services.
- Children who are not financially dependent on the client
- Foster children for whom the client receives foster care income.

NON-FILER

Non-filers are individuals who do not expect to file their own ta return AND meet an exception to the tax depend rules.

A non-filer Assistance Unit will consist of themselves, and if living in the same home include:

- The individual's spouse
- Any of their children under age 19

If a non-filer is under age 19, and if living in the same home include:

- The child's natural, adoptive and stepparent, and
- Any siblings they live with who are under age 19.

NOTE: Anytime there is a change in family composition that results in an increase or decrease in income clients must report this to their Case Managers (proof not required for income sources that remain the same, only for new sources).

COMMENTS:_____

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INCOME

The Ryan White Program is designed to serve persons at greatest need, so eligibility requires that an individual has low income. For the program in Nevada, eligibility is for those who have a household income that is at or below 400% of the Federal Poverty Level (FPL).

Income Source Documents

Income Source Documents
☐ Paycheck Stubs or Employment Statement for the last month *(most recent)*
☐ Annual Award Letter: Social Security, Supplemental Social Security (SSI), Social Security Disability Income (SSDI), Veterans Benefits, Annual Pension, Retirement, etc.
☐ Other Award Letter: Temporary Assistance for Needy Families (TANF), Unemployment, Child support/alimony etc.
☐ One (1) Month of Bank Statements *(only if pay stubs or annual statements cannot be provided)*
☐ Pre-Paid Debit Card Statements
☐ Profit and Loss Statement from Self-Employment (CGD 16-04)
☐ Other Source of Income: _____
☐ No Income: *Complete the Attestation of No Income Below*

Process

Proof of income must be provided for the client and each adult member of his or her household. Adult household members include a spouse and tax dependents. The proof of income must include the payee's name. The following documentation is acceptable in verifying and determining income:

- Paycheck Stubs or Employment Statements
- Annual Award Letter (Social Security, Supplemental Social Security (SSI), Social Security Disability Income (SSDI), Veterans Benefits, Annual Pension, Retirement, etc.
- Other Award Letter: Temporary Assistance for Needy Families (TANF), Unemployment, Child support/alimony etc.
- One (1) month of Bank Statement (only if pay stubs or annual statement cannot be provided)
- Pre-Paid Debit Card Statements
- Profit and Loss Statement form Self-Employment
- Other Sources of Income
- No Income: Complete the Attestation of No Income.

The following types of documentation are acceptable forms of income verification:

- Copy of most current year's 1040, or 1040EZ signed by the client.
- Payroll stubs (2 consecutive stubs) dated within the 30 days before the new/returning application or biannual (twice a year) recertification.
- Statement from an employer on official company letterhead showing gross pay for the 30-days before the new/returning application or biannual (twice a year) recertification.
- Letter with current year's date from the department of Social Security Services detailing annual benefits is acceptable as financial proof, if applicable, (e.g., SSI/SSDI letter with current year annual SSI/SSDI financial benefits).

COMMENTS:_____

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Non-Taxable Income/Unearned Income Sources

Unearned income is all sources of income that are not earned.

Non-Taxable Income Sources
Do you, or anyone in your household, have one of the following types of non-taxable income sources?
☐ No, I nor anyone in my household has non-taxable income sources
☐ Yes, I or someone in my household has non-taxable income sources *(check all that apply)*
☐ Supplement Social Security Income (SSI)
☐ Workers Compensation
☐ Child Support Received
☐ Veteran's Disability Income
☐ Proceeds from Loans (Student/Bank Loans)
Monthly Self $ _____ **Monthly Spouse/Household $** _____

Process

1. **No, I nor anyone in my household, have one of the following types of non-taxable income sources?**

   No further action is necessary.

2. **Yes, I or someone in my household has non-taxable income sources (check all that apply)**

   Check all that apply and determine income amounts that client has earned on a monthly basis. Place that amount in the box.

   The following are considered non-taxable/

   - Supplement Social Security (SSI)
   - Workers Compensation
   - Child Support Received
   - Veterans Disability Income
   - Proceeds from loans (student/bank loans)

   The following are also types of income that are not from employment and must also be documented to determine eligibility. Please make note in the space available.

   - Unemployment Compensation
   - Veterans Pension Benefits
   - Pension or Retirement Benefits
   - Temporary cash Assistance for Needy Families (TANF)

3. **Calculate the total monthly income reported by client.**

Notes:

Non-Traditional Income

- Clients with non-traditional income, that are either self-employed, do not receive a paystub, or are paid in cash, must provide the Profit and Loss Statement for Self-Employment (CGD 16-04). This includes categorically ineligible clients working for cash payment such as day laborers, Las Vegas Strip/Freemont Street entertainers, and sex workers.

Not Considered Income

The following are not to be considered as income sources when determining eligibility:

- Supplemental Nutrition Assistance Program (SNAP), previously Food Stamps, is not considered income when determining eligibility.
- Financial Aid, including scholarships and fellowships, received by individuals attending school is not considered income when determining eligibility.
- One-time payments (for example CARES Act subsidies) are not considered income when determining eligibility.
- Child Support payments are not considered income when determining eligibility.
- 401K, if not acsessed.
- Non-accessible income (such as trust funds)
- Lump-Sum Payments (such as a bonus)

COMMENTS:_____

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Taxable Income Sources

Taxable Income Sources

Do you, or anyone in your household, have one of the following types of taxable income sources?

☐ No, I nor anyone in my household has taxable income sources

☐ Yes, I or someone in my household has a taxable income source *(check all that apply)*

☐ Wages, Salary, & Tips (Gross- before taxes)	☐ Capital Gains
☐ Social Security Retirement Income	☐ Rental Income (Net)
☐ Social Security Disability Income	☐ Unemployment Compensation
☐ Business / Self Employment Income	☐ Taxable amount from Pensions & IRAs Distributions
☐ Taxable Interest and Dividends	☐ Other income not exempted (Jury Duty Pay, Gambling Winnings)

How often are you or your spouse/household member paid?

Every Week:	☐ Self	☐ Spouse/Household
Every Two Weeks:	☐ Self	☐ Spouse/Household
Semi Monthly- *The 15th and 30th of the Month*:	☐ Self	☐ Spouse/Household
Monthly:	☐ Self	☐ Spouse/Household
Unstable Income:	☐ Self	☐ Spouse/Household

Monthly Self (before taxes) $ _____ **Monthly Spouse/Household (before taxes) $** _____

Process

Check the following as appropriate:

1. No, I nor anyone in my household has taxable incomes sources

    - If client checks this box, try to ascertain how the client is supporting themselves and/or household.

2. Yes, I or someone in my household has a taxable income source (check all that apply)

    - Check to ensure that all income sources that reported match those documents provided by the client or if they have/are providing documentation matching those items checked.

3. How often are you or your spouse/household member paid?

    - Ensure that clients provided documentation matches against items marked.

4. Total the amount of income made earned by client and/or spouse/household member and place monthly amount in appropriate box.

Notes:

Spousal income must be reported and documented for any client who is reported as married. This must be included on the Common Guidance Document (CGD) applications and the documentation requirements are the same as those for the client. If the couple is legally

separated or divorced, this should be noted. In that case, spousal income is not reported, and the spouse is not included in the household size.

For individuals with regular, non-seasonal employment, documentation must be with the three (3) most recent consecutive paystubs. The most recent pay stub can be no more than 30 days older than the date that the application was signed by the client.

COMMENTS:_____

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Deductions

Deductions are typically expenses that the taxpayer incurs during the year that can be applied against or subtracted from their gross income when calculating income for eligibility purposes.

Deductions	
Do you, or anyone in your household, have one of the following types of deductions?	
☐ No, I nor anyone in my household has deductions	
☐ Yes, I or someone in my household has deductions *(check all that apply)*	
☐ Health Savings Account Deductions	☐ Workplace Retirement Plan: 401K
☐ Self-Employment Health Insurance Costs	☐ Workplace Retirement Plan: 403B
☐ Health Costs (Insurance Premiums- Paid by Self)	☐ Traditional IRA (not a Roth IRA)
Monthly Self $ _____	**Monthly Spouse/Household $** _____

Process

1. No, I nor anyone in my household has deductions
   - Place $0 in the corresponding boxes

2. Yes, I or someone in my household has deductions – Check all that apply
   - Determine who is receiving the amount and inquire on the monthly amount
   - Calculate the total monthly amount of all deductions and place the amount in the corresponding box.

COMMENTS:_____

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MODIFIED ADJUSTED GROSS INCOME (MAGI)

The Nevada Ryan White Program(s) uses a Modified Adjusted Gross Income (MAGI) to calculate client income. The calculated income is used to identify the client's federal poverty limit. Proof of household income is also based on Modified Adjusted Gross Income (MAGI). Household income includes the client's income and all income of anyone the client claims on their taxes or the income of someone who claims the client as a dependent on their taxes.

Monthly MAGI Income Formula:

- Monthly Income Minus (-) Deductions

FOR ADMINISTRATIVE USE ONLY

Monthly MAGI Income Formula: Monthly Taxable Income Sources minus (-) Monthly Deductions

For taxable income, follow these instructions to calculate monthly MAGI income:

- *If the individual is Paid Every Week, Every Two Weeks, or has Unstable Income: 1) Add the individual's checks together for the 30-day period, 2) Divide that by the number of checks to calculate an average, 3) Multiply the average by, 4.3 if paid weekly, or 2.15 if paid every two weeks. Repeat for each applicable individual (spouse or household member)*
- *If the individual is Paid Semi-Monthly: Add the two amounts together. Repeat for each applicable individual (spouse or household member).*
- *If the individual is Paid Monthly: No calculation is needed.*

Monthly MAGI Income: Self $ _____ Spouse/Household $ _____ *Note: (Non-Taxable Income is not included in MAGI)*

Annual MAGI Income: $_____

Process

1. **Determine client(s) and spouse/household monthly income**

   - If the individual is paid every week, every two weeks or has unstable income:

     1) Add the individual's checks together for the 30-day period
     2) Divide that by the number of checks to calculate an average
     3) Multiply the average by 4.3 (weekly) or 2.15 (if paid every two weeks). Repeat for each applicable individual (spouse or household member)

   - If the individual is Paid Semi-Monthly: add the two amounts together.

   - If the individual is Paid Monthly: No calculation is needed.

2. **Compare client's annual household income to FPL to determine eligibility.**

Circumstances may vary based on the availability of documentation.

If a client's weekly income fluctuates greatly (e.g., day labor),

- Add the individual's checks together for the 30-day period,
- Divide that by the number of checks to calculate an average,
- Multiply the average by 4.3 if paid weekly or 2.15 if paid every two weeks.

- Add the weekly totals together, and then divide by the number of weeks worked to determine the average weekly gross amount.
- Once the average weekly gross amount is determined, use the weekly income calculation above to determine the annual income.

Repeat for each applicable individual (spouse or household member)

Notes:

- Do not include bonuses, holiday pay, commissions and/or overtime, unless it is received on a regular basis or the holiday pay is received in lieu of regular pay (i.e., vacation pay)

- Individuals which, by contract or self-employment, receive their annual income in a period of time shorter than one year shall also have that income averaged over a 12-month period provide the income from the contract is not received on an hourly or piecework basis. (These household may include some school employees, sharecroppers, farmers, and other self-employed households. This does not include migrant or seasonal farm workers.)

MAGI - ASSISTANCE UNIT DETERMINATION (HOUSEHOLD)

Under MAGI the number of assistance units (household members) will depend on how the client expects to file taxes for the year in which eligibility will be determined. Case Managers should identify the related household members and determine their individual tax filing status to determine eligibility. Under IRS rules there are 5 filing status:

- Single
- Married Filing Jointly
- Married Filing Separately
- Head of Household
- Qualifying Widow(er) with Dependent Child

IRS rules state a tax filer's household will include themselves, the joint filer (if applicable) and any dependents they claim on their federal tax return including any tax dependents no living in the home. Use Household Size information provided by the client to determine the filing status of each household member.

Tax Dependent

A tax dependent is an individual who expects to be, or is claimed as a dependent by another tax filer. A tax dependent's Assistant Unit will be the same as the individual who is claiming them as a dependent unless:

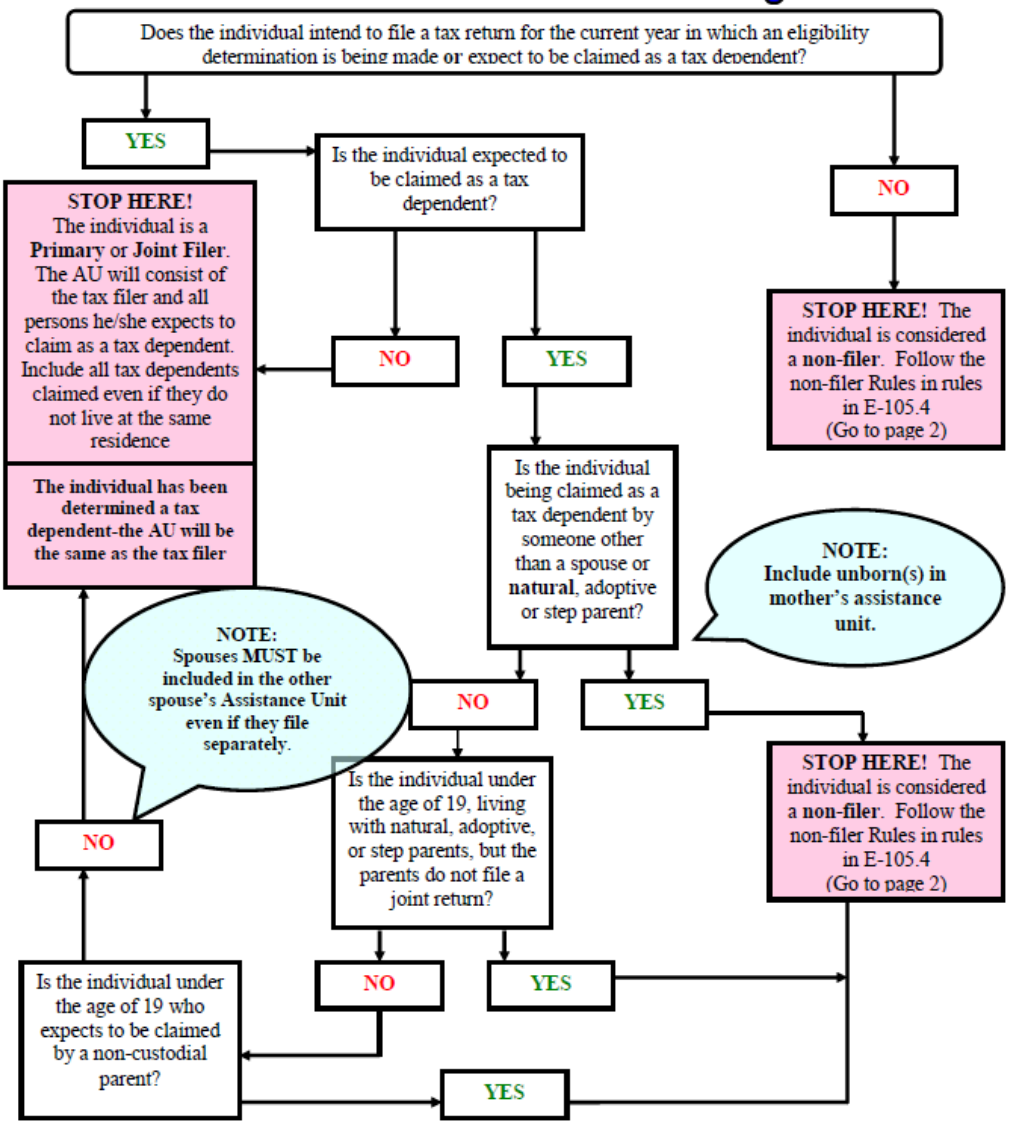
1. They are or expect to be claimed by another individual who is not a spouse or biological, adoptive or step parent.
2. They are a child under age 19, living with both parents, and the parents do not file a joint tax return.
3. Or they are child under age 19, and are being claimed by a non-custodial parent

Spouses/Domestic Partners

When determining an individual's assistance unit, spouses/domestic partners must be included in each other's assistance unit. This includes both traditional and same gender couples. It does not matter if they file a joint or separate tax return or if one expects to be claimed as a tax dependent. They must be in each other's assistant unit.

MAGI Assistance Unit Determination

Medical Assistance Manual E-105.1 through 105.3



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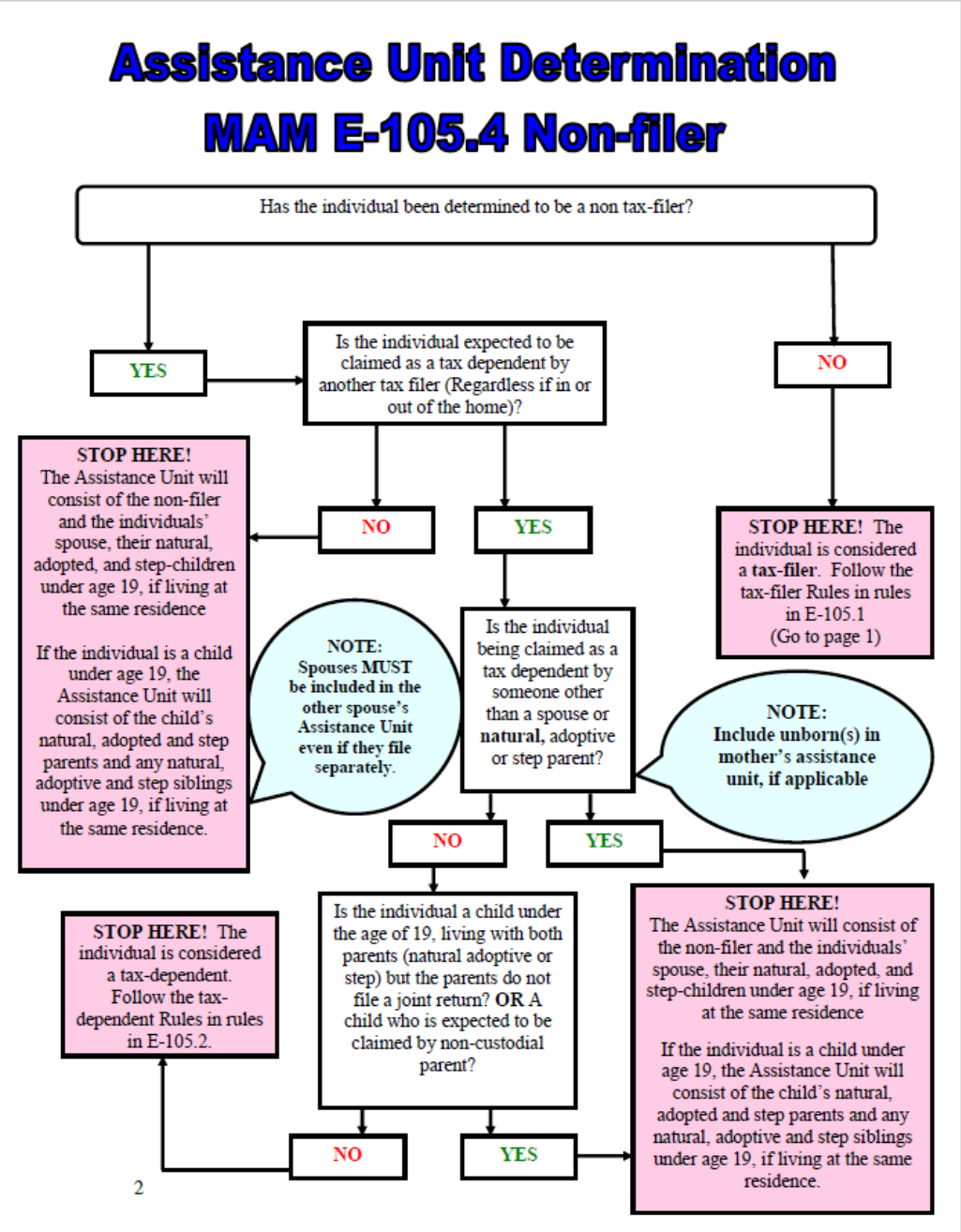

Non-Filer Rules

Non-filers are individual who do not expect to file their own tax return AND meets an exception to the tax expectation rules. A non-filer assistance Unit will consist of themselves, and if living in the same home include:

- The individuals Spouse
- Any of their children under age 19

If the non-filer is under age 19, and if living in the same home include:

- The child's natural, adoptive and step parent, and
- Any siblings they live with who are under age 19

COMMENTS:_____

Attestation of No Income

Clients who state that their household has zero income are required to complete the Attestation of No Income found in the Common Guidance Documents 18-04a New Client Application (English/Spanish), and 18-05a Annual Client Application (English/Spanish) and the no-change in income on the 18-06a

Attestation of No Income
I attest that I have no verifiable income. I agree that if my financial status changes, I must immediately notify the Ryan White Part All Parts (ABCD) eligibility agency and provide documentation of income. I am receiving financial assistance with food, water, and basic needs from: _____ Client Signature: _____ Date: _____

Process

1. I am receiving financial assistance with food, water, and basic needs from: Have the client state how his basic needs are being met.
2. Client Signature: Have client sign his/her full name.
3. Date: The date should equal the day that the application was complete.

Notes:

Clients that declare no income must verify other means of support this includes:

- A letter of support from the person(s) providing in-kind support to the client.
- A completed Dependent Support From (CDG 15-48)

COMMENTS:_____

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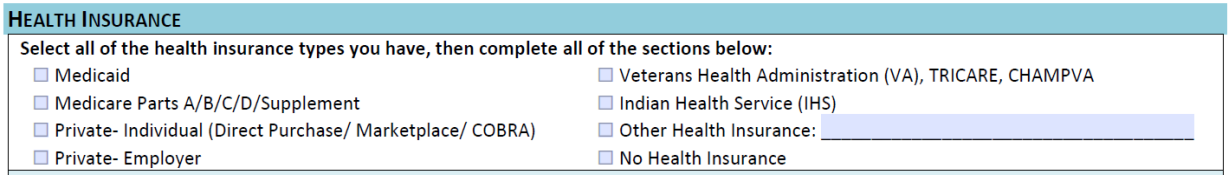
HEALTH INSURANCE

As stated in HRSA PCN #13-05 the Ryan White Program is, "expected to vigorously pursue enrollment into health care coverage for which their clients may be eligible (e.g., Medicaid, CHIP, Medicare, state-funded HIV/AIDS programs, employer-sponsored health insurance coverage, and/or other private health insurance)".



HEALTH INSURANCE

Select all of the health insurance types you have, then complete all of the sections below:

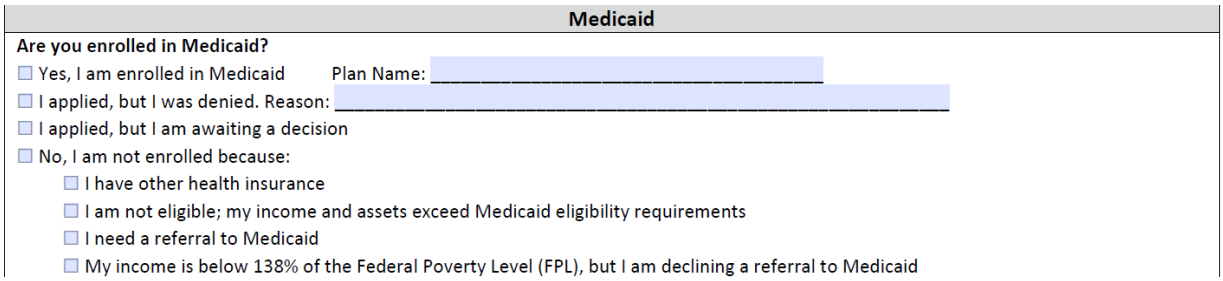
- ☐ Medicaid
- ☐ Medicare Parts A/B/C/D/Supplement
- ☐ Private- Individual (Direct Purchase/ Marketplace/ COBRA)
- ☐ Private- Employer
- ☐ Veterans Health Administration (VA), TRICARE, CHAMPVA
- ☐ Indian Health Service (IHS)
- ☐ Other Health Insurance: _____
- ☐ No Health Insurance

Determine if client(s) are eligible for insurance. Clients eligible for private marketplace or employer insurance will be required to provide proof of insurance. Sub-recipient(s) are responsible to ensure that clients are screened for other payer sources covered by Federal or State programs such as Medicare and Medicaid., all other forms of insurance or third-party payers (such a private and commercial insurance plans) and other payers.

Medicaid

Medicaid is a state and federally-funded entitlement program. The Nevada Department of Children and Families (DCF) and/or the Social Security Administration (SSA) determine Medicaid recipient eligibility. Individuals who might be eligible for Medicaid include:

- Single parent household with children under age 18.
- Two parent household unemployed or underemployed.
- Individuals with a disability as determined by the SSA or DCF.



Medicaid

Are you enrolled in Medicaid?

- ☐ Yes, I am enrolled in Medicaid Plan Name: _____
- ☐ I applied, but I was denied. Reason: _____
- ☐ I applied, but I am awaiting a decision
- ☐ No, I am not enrolled because:
  - ☐ I have other health insurance
  - ☐ I am not eligible; my income and assets exceed Medicaid eligibility requirements
  - ☐ I need a referral to Medicaid
  - ☐ My income is below 138% of the Federal Poverty Level (FPL), but I am declining a referral to Medicaid

Process

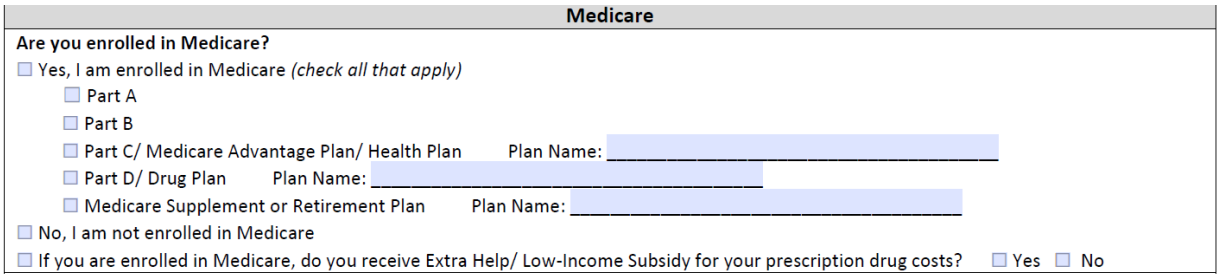
1. Verify if client is enrolled in Medicaid, or
2. If yes, check and add the Plan Name, or
3. Check if they have applied and were denied, determine the reason of denial and place reason in box, or
4. Check of client has applied and is awaiting decision, or
5. If client has not applied, determine reason why and place a check on any that apply.

Notes:

- Clients who are Medicaid eligible will not be eligible for Ryan White services where the same service is covered by Medicaid. Eligibility staff must verify current Medicaid enrollment.

Medicare

Medicare is a federally-funded entitlement program administered by the Centers for Medicare and Medicaid Services. Medicare is health insurance for people aged 65 or older, under age 65 with certain disabilities, or at any age with end-stage renal disease. Most people receive Medicare health coverage in one of two ways: an original Medicare plan (Part A Hospital Insurance or Part B Medical Insurance), or a Medicare Advantage Plan (sometimes referred to as Part C or MA Plans). Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D).



Medicare

Are you enrolled in Medicare?

☐ Yes, I am enrolled in Medicare *(check all that apply)*

- ☐ Part A
- ☐ Part B
- ☐ Part C/ Medicare Advantage Plan/ Health Plan Plan Name: _____
- ☐ Part D/ Drug Plan Plan Name: _____
- ☐ Medicare Supplement or Retirement Plan Plan Name: _____

☐ No, I am not enrolled in Medicare

☐ If you are enrolled in Medicare, do you receive Extra Help/ Low-Income Subsidy for your prescription drug costs? ☐ Yes ☐ No

Process

1. Verify if the client does or does not have Medicare.

2. If yes, check all that apply –
   Part C/Medicare Advantage Plan/Health plan – Identify the Plan Name
   Part D/Drug Plan – Identify the Plan Name
   Medicare Supplement or Retirement Plan – Identify the Plan Name

3. If no is checked – does the client need assistance in determining if they need additional information to determine if they may qualify. (Refer to Medicare Counselor – AFN)

4. Check the box if they are enrolled in Medicare, check if Yes/No if they ae receiving extra help for prescription drug costs, if no – does the client need assistance in determining if they need additional information to determine if they may quality.

Notes:

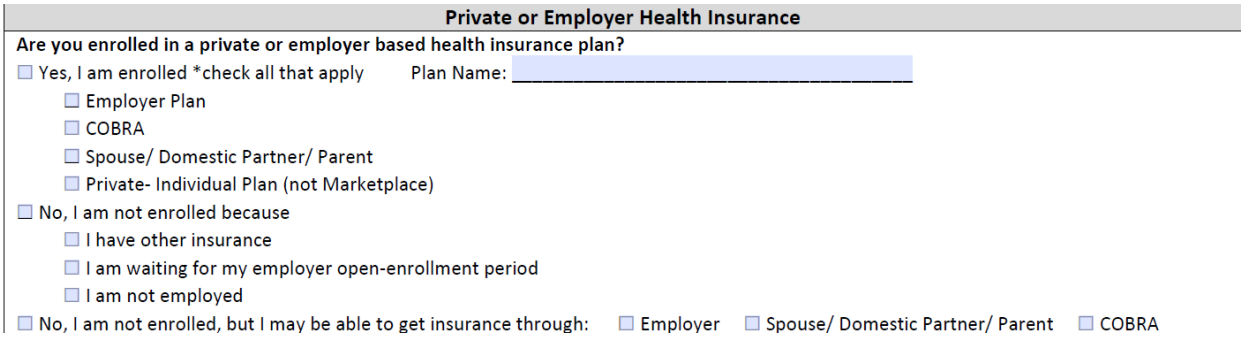
- Individuals who are eligible for Medicare must enroll in all coverage that is available before accessing Ryan White Part B services.

- Medicare Part recipients are required to enroll in a drug plan under Part D before accessing NMAP services.

There are two ways to get Medicare Part D prescription drug coverage:

- Join a Medicare Part D prescription drug plan that adds drug coverage to the original Medicare plan; or
- Join a Medicare plan (like an HMO) that includes prescription drug coverage as part of the plan (Part C Advantage Plan).

Private/Employer Health Insurance



Private or Employer Health Insurance

Are you enrolled in a private or employer based health insurance plan?

☐ Yes, I am enrolled *check all that apply Plan Name: _____

- ☐ Employer Plan
- ☐ COBRA
- ☐ Spouse/ Domestic Partner/ Parent
- ☐ Private- Individual Plan (not Marketplace)

☐ No, I am not enrolled because

- ☐ I have other insurance
- ☐ I am waiting for my employer open-enrollment period
- ☐ I am not employed

☐ No, I am not enrolled, but I may be able to get insurance through: ☐ Employer ☐ Spouse/ Domestic Partner/ Parent ☐ COBRA

Process

1. Verify if the client has Private/Employer Insurance
2. If yes, check those that apply and add the Plan Name.
3. If no, determine why not and check which applies.

IF THE CLIENT HAS INSURANCE

1. Obtain a copy of the insurance card (front and back) and policy coverage and maintain a copy in eligibility file.
2. Determine if the coverage is viable, including pharmaceutical coverage.
3. Determine the premium cost to the client, and if help is needed with their portion to maintain coverage (not everyone needs assistance with premium payments).
4. If assistance with premium payments is needed, refer the client (once determined eligible) for HIP CS services.
5. Determine if the client will have access to insurance, and when access will be available (usually there is an open enrollment period).
6. If open enrollment is not immediate, complete the Employer Insurance Verification Form stating the client will have access to insurance during open enrollment and document timeframe.
7. The client must access insurance during open enrollment and provide insurance documentation as specified above.

Notes:

- Refusal to access employer-based insurance is justification to deny eligibility. (Exception: If employer does not accept a third payer)

IF THE CLIENT HAS NO INSURANCE

1. Document steps taken to ensure insurance is not available.
2. Refer the client for NMAP services.
3. If the client is employed but without insurance, the client will need to provide proof that they have no access to insurance from their employer. This can be done in various ways. For example: Letter from employer.

Notes:

- Proper documentation is required. It is not acceptable to take a client's word they have no access to insurance when employed.

COMMENTS:_____

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Ryan White and Other Service Needs.

The goal is to gather an array of information to develop a comprehensive picture of the clients' needs in order to identify a client's service needs, including barriers, that prevent them receiving needed services or from continuing to stay in care.

RYAN WHITE AND OTHER SERVICE NEEDS

Are you consistently taking your medications as prescribed?	☐ Yes	☐ No
Do you need counseling or education about your medications?	☐ Yes	☐ No
Do you need counseling or education about Risk Reduction?	☐ Yes	☐ No
Do you have issues with stress and/or depression in your life?	☐ Yes	☐ No

Which Ryan White Services do you need?

☐ Assistance with Food and Meals	☐ Legal Services	☐ Psychosocial Support/ Support Groups
☐ Case Management	☐ Medical Copayment Financial Assistance	☐ Substance Use Therapy
☐ Dental Care	☐ Medical Nutrition Therapy (Dietician)	☐ Transportation Assistance
☐ Emergency Financial Assistance (Utilities, Rent)	☐ Medication Assistance	☐ Treatment Adherence
☐ Health Education/Risk Reduction	☐ Mental Health Therapy	☐ Vision Care
☐ Health Insurance Premium Assistance	☐ Prenatal Care	☐ Other: _____
☐ Housing Assistance	☐ Primary or Specialty Medical Care	☐ Other: _____

Process

Assist the client in ascertaining what services are needed.

1. Are you consistently taking your medications as prescribed:
    - If No – try and determine why, please refer client to a subrecipient who provides HERR services
2. Do you need counseling or education about your medications:
    - If Yes – Please refer client to NMAP for assistance.
3. Do you need counseling or education about Risk Reduction:
    - If Yes – Please refer client to a subrecipient who provides HERR services
4. Do you have issues with stress and/or depression in your life:
    - If Yes – Please refer client to a subrecipients who provides Mental Health Services

Which Ryan White Services do you Need?

Service	Category	Northern Provider	Southern Provider
Assistance with Food and Meals	Refer client to Ryan White Food Assistance/Home Delivered Meals provider.	AHN	AFAN, North Country, Nye County
Case Management (Non-Medical)	That would be you.	AHN, ACCEPT, HOPES, CCS	AHN, The Center, AFAN, SNHD
Case Management (Medical)	Refer the client to Ryan White Outpatient/Ambulatory Care Provider	HOPES	AHF, COMC, Huntrdige Clinic, North Country, SNHD, UMC
Dental Care	Refer the client to Ryan White Oral Health Provider and/or Health Insurance Premium and Cost	AHN	UMC, UNLV (Oral) Liberty Dental

	Sharing Provider		
Emergency Financial Assistance (Utilities, Rent)	Refer the client to Ryan White Emergency Financial Assistance provider.	HOPES (Utilities only)	Golden rainbow, North County, Nye County
Health Education/Risk Reduction	Refer the client to a Ryan White HERR provider	ACCEPT	AFAN, The Center, COMC, Dignity Health, Golden Rainbow
Health Insurance Premium Assistance	Refer the client to a Ryan White Health Insurance Premium and Cost Sharing Provider	AHN	AHN, North Country
Housing Assistance	Refer client to HOPWA program, prior to Ryan White EFA provider, and/or Ryan White Housing providing agency.	HOPES (HOPWA & Housing)	City of Las Vegas (HOPWA), Golden Rainbow (EFA), North Country (EFA), Nye County (EFA)
Legal Services	Refer the client to Ryan White Legal Provider	Nevada Legal Services	Nevada Legal Services
Medical Copayment Financial Assistance	Refer the client to a Ryan White Health Insurance Premium and Cost Sharing Provider	AHN	AHN, North Country
Medical Nutrition Therapy (Dietician)	Refer client to Ryan White Medical Nutrition Therapy Provider.	AHN	AFAN, Dignity Health, SNHD,
Medication Assistance	Refer the client to NMAP	AHN	AHN
Mental Health Services	Refer the client to Ryan White Mental Health Services Provider	HOPES	AFAN, CCC, COMC, Horizon Ridge
Prenatal Care			
Primary or Specialty Medical Care	Refer the client to Ryan White Medical Case Management Provider	HOPES	AFAN, AHF, AHN, CCC, COMC, Horizon Ridge, NARES, North Country, Nye County, SNHD, UMC
Psychosocial Support/Support Groups	Refer the client to Ryan White Psychosocial Support Provider.	HOPES	CCC, COMC, Horizon Ridge, North Country
Substance Use Therapy	Refer the Client to Ryan White Substance Use Therapy Provider		
Transportation Assistance	Refer client to Ryan White Medical Transportation provider.	AHN, HOPES, ACCEPT	AFAN, COMC, NARES, North Country, Nye County
Treatment Adherence	Refer the client to Ryan White Outpatient/Ambulatory Care Provider		AHF, COMC, Huntrdige Clinic, North Country, SNHD, UMC
Vision Care	Refer client to Ryan White EFA provider	Co-Pay AHN	Golden rainbow, North County, Nye County
Other (Health Insurance)	Refer the client to a Ryan White Health Insurance Premium and Cost Sharing Provider	AHN	AHN, North Country

Notes: Make referral to appropriate service provider on behalf of client through CAREWare, or other appropriate means, but follow all confidentiality rules for the protection of the client.

COMMENTS:_____

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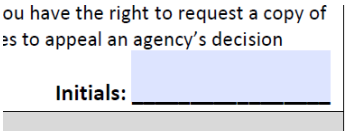
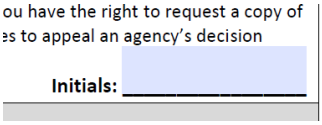
RIGHTS AND RESPONSIBLITIES

The Rights and Responsibilities statements reflect client's expectations from the program, as well as their responsibilities to the program, as individuals seeking medical and support services from Ryan White All Parts (ABCD) Programs in the State of Nevada.

Client Rights:



Client Responsibilities:



Process

- Please read (or have the client read) his/her Rights and Responsibilities.
- Have client initial that he/she has read and understands their rights and responsibilities, but only after he/she has acknowledged that they fully understand these rights and responsibilities and their questions and concerns have been answered.

COMMENTS:_____

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Release of Confidential Information (ROI)

RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize any of the agencies listed below who participate in the community based Ryan White All Parts (ABCD) Programs in the State of Nevada to release and/or share information concerning my eligibility, medical record status, and information concerning my HIV screening, diagnosis, and treatment. The following agencies/programs authorized are:

Process

1. Case Manager will read or have the client read the above statement and go through the list of current providers.
2. (Optional) The client can fill in the name of his physician
3. (Optional) the client can fill in the name of his partner/spouse/other (this would be preferably his emergency contact)

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White All Parts (ABCD) program. I may withdraw this consent by notifying, in writing, the Ryan White agency where my eligibility was completed. I understand that my records are protected under federal HIPAA regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent in writing any time, except to the extent that any action has been taken while it is still in force. This consent expires automatically one (1) year from registration or previously signed consent.

Process

1. Case manager will read or have the client read the above statement.

Notes:

The client cannot choose which agencies he wishes to place on this list, and which to remove. If the question arises, assure the client that ONLY those agencies who he/she has sought services from will have access to their information.

COMMENTS:_____

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AFFIDAVIT

AFFIDAVIT

I fully understand that by applying for this program, I am divulging personal information that will be used to assist me with benefits associated with the Nevada Ryan White Parts A, B, C, D Programs. I understand this information will be kept confidential, but will be used by staff to review my eligibility for this program. Also, by signing this form, I understand that the information contained within may be used to verify all application information provided. By applying for this program, I understand that this does not mean that my application will be accepted, as funds are limited and eligibility requirements must be met.

I fully acknowledge:

1. **It is my responsibility to renew my eligibility every 6 months on or before my birth month and 6 months following (half-birth month).**
2. **It is my responsibility to report any changes to my household income, my address, my contact information, my health insurance, or any other information that may affect my eligibility or services.**
3. **If I fail to recertify, my eligibility and benefits will be terminated.**

I certify that the information provided in this application is true and accurate as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and a termination of benefits.

_____	_____	_____
Printed Name	**Signature**	**Date**

Process

1. Case Manager will read or have the client read the statement.
2. Case Manager will ensure that the client understands the statement prior to client signing.

COMMENTS:_____

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UNIVERSAL ELIGIBLITY APPLICATION
ANNUAL CLIENT REVIEW
CGD 18-05

Process

1. Case Manger will follow all the same procedures as the listed in the Universal Eligibility Application – Brand New Client (CGD 18-04).

2. The only change is there is no need for HIV/AIDS Status and Diagnosis Information (see 18-04, page 2) or no need for Proof of Diagnosis (see 18-04 page. 2), as HRSA regulations allow for this information to be gathered only once, at the client's initial eligibility.

COMMENTS:_____

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Universal Eligibility Application
Six-Month Self- Attestation
CGD 18-06

Name: _____ **Birth Date:** _____

Mailing Address: _____ **City:** _____ **Zip:** _____

Primary Phone: _____ **Alternate Phone:** _____

If you are returning this form via mail, fax, or email, how would you like to receive confirmation that the agency received this form?
Please be sure the information at the top of page one is up to date.

☐ **Mail** ☐ **Fax** ☐ **Email** ☐ **Phone**

For Administrative Use Only:
New Ryan White Eligibility: Start Date: _____ End Date: _____
Case Manager/ Eligibility Specialist Name: _____

Process

1. **Name**: Clients Name
2. **Birth Date**: Clients Date of Birth
3. **Mailing Address**: Client Mailing Address
   Should match their Eligibility Packet and/or provided documentation.
4. **City**: Should match their Eligibility Packet and/or provided documentation.
5. **Zip**: Should match their Eligibility Packet and/or provided documentation.
6. **Primary Phone**: Should match their Eligibility Packet and/or provided documentation.
7. **Alternate Phone**: (optional)
8. **Alternative mailing** – Client/Case Manager should check whichever is appropriate, if one-on-one.
9. **Start Date**: Should match their Eligibility Packet and/or provided documentation.
10. **End Date**: Should match their Eligibility Packet and/or provided documentation.
11. **Case Manager/Eligibility Specialist Name**: The case manager/eligibility specialist who is currently executing this application will place their name in here. This may or may not be the original case manager/eligibility specialist who completed the Initial or Annual packets.

RESIDENCY

Since your Annual Certification six months ago, have you moved/changed residence?

☐ No, my address has not changed.
☐ Yes, my address has changed. (*Complete the Residency Section)*

Process

1. No, my address has not changed: No need for further documentation
2. Yes, my address has changed: continue to Residency section (page 3) of the packet, follow the instructions provided in page(s) 11 - 13 of this Manual.
   Ensure that client has provided corresponding documentation for the change.

HOUSEHOLD SIZE

Since your Annual Certification six months ago, has your household size changed?

☐ No, there is no change in my household size.

☐ Yes, my household size has changed. (*Complete the Household Size Section)*

Process

1. No, my address has not changed: No need for further documentation
2. Yes, my household size has changed: continue to Household Size section (page3) of the packet, follow the instructions provided in page(s) 14 - 15 of this Manual.
    - Ensure that client has provided corresponding documentation for the change.

INCOME

Since your Annual Certification six months ago, has your income changed?

☐ No, my income has remained the same.

☐ Yes, my income has changed. *(Complete the Income Section and Attach All Income Documents)*

Process

1. No, my address has not changed: No need for further documentation
2. Yes, income has changed: continue to Income section (page 3- 4) of the packet, follow the instructions provided in page(s) 16 - 27 of this Manual.
    - Ensure that client has provided corresponding documentation for the change.

HEALTH INSURANCE

Since your Annual Certification six months ago, has your insurance status changed?

☐ No, there is no change in my insurance status.

☐ Yes, my insurance status has changed. *(Complete the Health Insurance Section)*

Since your Annual Certification six months ago, have you become eligible for employer insurance, or marketplace insurance, or Medicaid, or Medicare?

☐ No, has been no change in insurance eligibility

☐ Yes, I have become eligible for health insurance *(Complete the Health Insurance Section)*

Process

Since your Annual Certification six months ago, has your insurance status changed?

1. No, there is no change in my insurance status: No need for further documentation
2. Yes, my insurance status has changed: continue to Health Insurance section (page 5) of the packet, follow the instructions provided in page(s) 28 - 31 of this Manual.
    - Ensure that client has provided corresponding documentation for the change.

Since your Annual Certification six months ago, have you become eligible for employer insurance, or marketplace insurance or Medicaid or Medicare?

1. No, there is no change in my insurance status: No need for further documentation
2. Yes, I have become eligible for health insurance: continue to Health Insurance section (page 5) of the packet, follow the instructions provided in page(s) 28 - 31 of this Manual.
    - Ensure that client has provided corresponding documentation for the change.

RYAN WHITE AND OTHER SERVICE NEEDS

Are you consistently taking your medications as prescribed?	☐ Yes	☐ No
Do you need counseling or education about your medications?	☐ Yes	☐ No
Do you need counseling or education about Risk Reduction?	☐ Yes	☐ No
Do you have issues with stress and/or depression in your life?	☐ Yes	☐ No

Which Ryan White Services do you need?

☐ Assistance with Food and Meals	☐ Legal Services	☐ Psychosocial Support/ Support Groups
☐ Case Management	☐ Medical Copayment Financial Assistance	☐ Substance Use Therapy
☐ Dental Care	☐ Medical Nutrition Therapy (Dietician)	☐ Transportation Assistance
☐ Emergency Financial Assistance (Utilities, Rent)	☐ Medication Assistance	☐ Treatment Adherence
☐ Health Education/Risk Reduction	☐ Mental Health Therapy	☐ Vision Care
☐ Health Insurance Premium Assistance	☐ Prenatal Care	☐ Other: _____
☐ Housing Assistance	☐ Primary or Specialty Medical Care	☐ Other: _____

Process:

1. Case manager will check any changes or requests made by the client.
2. Follow the instructions provided on page(s) 32 - 34 in this Manual.

AFFIDAVIT

I fully understand that by applying for this program, I am divulging personal information that will be used to assist me with benefits associated with the Nevada Ryan White Parts A, B, C, D Programs. I understand this information will be kept confidential, but will be used by staff to review my eligibility for this program. Also, by signing this form, I understand that the information contained within may be used to verify all application information provided. By applying for this program, I understand that this does not mean that my application will be accepted, as funds are limited and eligibility requirements must be met.

I fully acknowledge:

1. **It is my responsibility to renew my eligibility every 6 months on or before my birth month and 6 months following (half-birth month).**
2. **It is my responsibility to report any changes to my household income, my address, my contact information, my health insurance, or any other information that may affect my eligibility or services.**
3. **If I fail to recertify, my eligibility and benefits will be terminated.**

I certify that the information provided in this application is true and accurate as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and a termination of benefits.

_____	_____	_____
Printed Name	**Signature**	**Date**

Process

1. Case Manager will read and/or have the client read the acknowledgement prior to signing the document to ensure that the client fully understands the acknowledgement.
2. Have Client Print their name, provide their signature, and place the date which the application is completed where appropriate.

COMMON GUIDANCE DOCUMENT 15-39
REQUEST FOR PROOF OF DIAGNOSIS

Purpose: This document will be used only when the client has no proof of a Positive HIV Diagnosis as required for eligibility purposes

Client Name _____ DOB: _____

The client noted above has requested services from the Ryan White HIV/AIDS Program. The Common Guidance from Ryan White Parts ABCD requires medical verification of diagnosis to determine eligibility for services. This is only at the client's initial enrollment only.

Process

1. Client will fill in their first and last name and/or the name known by the medical provider.
2. Client will fill in Date of Birth.
    - **The name and DOB should match the name and DOB given in the eligibility packet.**

This section is to be completed by the client only if the medical provider is not listed on the Universal Consent for Release of Confidential Information

I hereby give my permission to _____ to release the required information to the Ryan White Parts ABCD eligibility providers.

_____ _____

Client Signature Date

Process

1. Client will provide the **medical provider's name**.
2. Client will provide their signature
3. Client will provide the date the form was signed.

This section to be completed by your medical provider

DIAGNOSIS INFORMATION

☐ HIV Positive (not AIDS) ☐ CDC defined AIDS

☐ HIV Positive (AIDS Status Unknown) ☐ HIV Indeterminate

HIV Diagnosis Date: _____ AIDS Diagnosis Date: _____

If available, please attach client's latest CD4 and Viral Load lab work.

Clinician Printed Name: _____

Clinician Signature: _____

License Number: _____ State Issued: _____

Telephone Number: _____ Date: _____

Process

1. Upon return, Case Manager will ensure that all the information has been completed and if a (optional) a copy of the diagnosis was provided.

COMMENTS:_____

_____

_____

_____

_____

_____

COMMON GUIDANCE DOCUMENT 15-48
DEPENDENT SUPPORT FORM

Purpose: This form is to be used when client has no other documentation to meet the Income and or Residency requirement of eligibility. **The form is to be completed by whoever is providing assistance to the client.**

Date: _____
Client Name: _____ DOB: _____
Client Address: _____

Process

1. **Date:** Fill the date the Form was completed
2. **Client Name:** Name of the client should match the eligibility packet
3. **DOB:** Date of Birth should match that in the eligibility packet.
4. **Client Address:** This would be the address of the individual completing the document, and/or the location where the client is residing.

If client has no means of support, please indicate the current living arrangement:

☐ Permanent House Guest ☐ Temporary House Guest
☐ Transitional Housing ☐ Other: _____

Process

1. The best description appropriate to the clients living situation should be checked.

Do you provide financial assistance for the client, such as assistance with food, water, cash, or basic needs? ☐ Yes ☐ No

Process

1. Person providing assistance should check Yes or No if they are providing financial or supportive assistance to the client.
2. **IF** financial support is being provided, case manager should enquire to how much is being provided.

The person providing support for the above applicant certifies the following:

I, _____, hereby affirm, under penalty of perjury, that I have been providing support of the person named above and to the best of my knowledge declare that his person has no other primary means of support.

Process

1. **Name of the person providing support will be placed here.**

I have provided support (financial or room and board) since: _____

Supporter's Name (please print): _____

Address (if different than above): _____

Telephone Number: _____

Relation to the Client: _____

Supporter's Signature: _____

Process

1. Person providing the support should complete this section.
2. Case manager will review the document to ensure completeness.

COMMENTS:_____

_____

_____

_____

_____

_____

COMMON GUIDANCE DOCUMENT 15-50
VERIFICAITON OF RESIDENCE

Purpose: This form is to be used when client has no other documentation to meet the Residency requirement of eligibility.

Date: _____

Client Name: _____ DOB: _____

Process

1. **Date:** Dated when the Client has received the form.
2. **Client Name:** Client's name should match that on the eligibility packet.
3. **DOB:** Date of Birth should match that on the edibility packet.

My current physical address: _____
(Street)

_____
(City, State, Zip)

My monthly rent is: $ _____ / per month

My mailing address is: _____
(Street)
(*if different than physical address*)

_____
(City, State, Zip)

Process

1. **Physical Address:** Address should match that of the eligibility packet.
2. **Monthly Rent:** Exact monthly amount.
    - **No other supporting documentation other than this form is required.**
3. **Mailing Address:** This is completed only if the mailing and physical address are different.

I hereby declare that the above information regarding my current living situation is true.

_____ _____
(Client Signature) *(Date)*

I hereby declare that the above information regarding my tenants living situation is true.

_____ _____ _____
(Landlord name – please print) *(Landlord Signature)* *(Date)*

Process

1. **Client Signature:** Client's signature should match that provided in the eligibly packet.
2. **Date:** Dated prior to/or matches the date Landlord provided.
3. **Landlord Name:** Name of property owner, or authorized individual.
4. **Landlord Signature:** Signature of property owner, or authorized individual.
5. **Date:** Dated when landlord signature was provided.

COMMENTS:_____

_____

_____

_____

_____

COMMON GUIDANCE DOCUMENT 16-04
PROFIT AND LOSS STATEMENT FOR SELF-EMPLOYMENT

Purpose: This document is to completed only when the client is:
1) Declaring ownership of a business as his only form of income.
2) Declaring themselves as self-employed in a cash only occupation.

Client Name: _____ Date: _____
Company Name: _____
Company Address: _____
Type of Profession: _____

Process

1. **Client Name:** Name should match that on the eligibility packet.
2. **Date:** Date this form was completed.
3. **Company Name:** Only if one exists, if client is self-employed state **SELF**
4. **Company Address:** Only if one exists, if client is self-employed it should match eligibility packet.
5. **Type of Profession**: Enter the type of profession the client is engaged in.

Please fill in the fields that apply to you

GROSS INCOME	
Gross Sales *(Total amount of income from sales or services before subtracting expenses)*	$
Other Income *(Any other additional funds earned through the company such as payments from people leasing space or payments from investors)*	$
Total Gross Income Before Taxes and Expenses	$

Process

1. **Gross Sales**: Place in the total amount of income the client has earned within the last 3 months.
2. **Other Income**: Place in the total amount of income made from any other sources in the last 3 months.
3. **Total Gross Income Before Taxes and Expenses**: Place in the total of Gross Sales and Other Income.

EXPENSES	
Cost of Goods Sold- *(Direct costs to produce or obtain the goods sold by the company)*	$
Accounting and Legal Fees	$
Advertising	$
Insurance	$
Maintenance and Repairs	$
Supplies	$
Payroll Expenses- *(Salaries and wages for employees of the company)*	$
Postage	$
Rent	$
Licenses	$
Taxes	$
Telephone	$
Travel/Transportation	$
Utilities	$
Other	$
Other	$
Other	$
Total Expenses	$

Process

1. Expenses: Place in all amounts of expenses incurred by the client in the last 3 months that best match the description.
2. Total Expenses: Place in the total of amount of expenses identified above.

NET INCOME	
Gross Income	$
Total Taxes and Expenses	$
Total Net Income (Gross Income Minus Taxes and Expenses)	$

Process

1. **Gross Income**: Place in the total from Gross Income.
2. **Total Taxes and Expenses**: Place in the Total Expenses incurred.
3. **Total Net Income**: Subtract the Total Expense from the Gross Income.

I hereby declare that the above information regarding my personal business income is true.

Client Signature _____ Date _____

Process

1. Client Signature: Have client place his signature here.
2. Date: Have client place the date the document was signed.